STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	10/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00098705. This visit resulted in a partially extended survey-Immediate Jeopardy. Complaint number IN00098705 substantiated, Federal/State deficiencies related to the allegations are cited at F 282, F 329, F 385 and F 505. Survey date: October 24, 2011 Extended survey date: October 25, 2011 Facility Number: 010739 Provider Number: 155764 Aim Number: N/A Survey team: Regina Sanders, RN, TC Janet Adams, RN (10/25/11) Lara Richards, RN (10/25/11) Census Bed Type: SNF: 37 Residential: 73 Total: 110 Census Payor Type: Medicare: 35 Other: 75 Total: 110	F0000	The submission of this Plan of Correction does not indicate an admission by Spring Mill Health Campus that the findings and allegations contained herin are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Sample: 4 Supplemental sample: 2 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 10/30/11 Cathy Emswiller RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow physician's order, related to a Lasix (diuretic) order and PT (pro-time) and INR (international normalized ratio) (laboratory blood clotting test) laboratory (lab) tests for 3 of 4 residents reviewed for physician's orders in a sample of 4. (Residents #B, #D, and #E) Findings include: 1. Resident #B's record was reviewed on 10/24/11 at 2:15 p.m. The resident's diagnoses included, but were not limited	F0282	1. Resident #B no longer resides at facility. Residents #D and #E had pertinent labs drawn per MD orders during the time of the survey. No negative outcomes noted.2.Current residents with lab orders have the potential of being affected by this alleged deficiency. Physician orders for current residents were reviewed by Director of Health Services (DHS) or designee to ensure proper procedure for following physician's orders were carried out. No adverse side effects were noted.3. The deficiency was evaluated relative to system, education and compliance.	11/16/2011

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	to, deep vein thrombosis (blood clot) and hypertension. A) Resident #B's physician's telephone order, dated 10/12/11 at 2:40 p.m., which was two days after the facility had been notified of the PT/INR results, indicated, "(1) Hold Coumadin x (times) 2 day (sic) (2) then resume Coumadin @ (at) 2 mg daily (3) Draw PT/INR on Mon 10/17/11". The MAR, dated 10/11, indicated the resident was scheduled to get a PT/INR on 10/17/11. There were no initials on the MAR to indicate the PT/INR on 10/17/11 had been completed. The resident's record lacked documentation to indicate a PT/INR had been completed on 10/17/11. During an interview on 10/24/11 at 3:05 p.m., the Corporate RN Consultant indicated the lab company had not drawn the PT/INR on 10/17/11. During an interview on 10/24/11 at 4:15 p.m., the DHS (Director of Health Services) indicated a lab requisition had not been filled out for the PT/INR on 10/17/11. B) Resident #B's undated, physician's		In-servicing for licensed staff will be conducted by DHS or desgnee on facility guidelines of following physician's orders.4. The DHS or designee will audit physician's orders 7 days per week using the Tracking Log (see Attachment A) for 2 months, then audit 4 times per week for 2 months, then 3 times per week for 2 months. Results from the audits will be reviewed by the DHS or designee and forwarded to the Quality Assurance Committee for 6 months or until 100% compliance is achieved.	

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	order indicated an order for Lasix (diuretic) 40 mg (milligrams) daily at 6 a.m. The resident's Medication Administration Record (MAR), dated 10/11, indicated Lasix 40 mg daily, written on 10/13/11. The MAR indicated the Lasix was started on 10/14/11. The MAR indicated the medication was scheduled at 6 a.m.. The 6 a.m. had a line through it and written below it was, "upon rising". The MAR indicated the resident received the Lasix 40 mg at 9 a.m. on 10/15/11, 9:40 a.m. on 10/16/11, 8 a.m. on 10/17/11, 11 a.m. on 10/18/11, and there was not time documented for 10/19/11 and 10/20/11. During an interview on 10/24/11 at 3:05 p.m., the Corporate RN Nurse Consultant indicated the Lasix had not been given as ordered by the physician. 2. Resident #D's record was reviewed on 10/24/11 at 11:50 a.m. The resident's diagnoses included, but were not limited to, multiple pulmonary emboli (blood clots) and coronary artery disease. A physician's telephone order, dated 10/05/11 at 2 p.m., indicated to discontinue the previous order for Coumadin and to start Coumadin 2.5 mg for two days then Coumadin 5 mg for one			

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	day and alternate the doses, and to repeat the PT/INR in 10 days on 10/15/11. There was a lack of documentation to indicate the PT/INR had been completed on 10/15/11 as ordered by the physician. During an interview on 10/24/11 at 12:15 p.m., RN #1 indicated the PT/INR had not been completed because 10/15/11 was a week-end (Saturday). She indicated there was no physician's order to change the date of the PT/INR. During an interview on 10/24/11 at 1:10 p.m., RN #1 indicated the lab company will do labs on the week-end but they are considered STAT (immediately) and the nurse has to call them. She indicated the nurse had not called the lab to tell them the PT/INR was ordered for 10/15/11. 3. Resident #E's record was reviewed on 10/24/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and coronary artery disease. A physician's telephone order, dated 10/12/11 indicated an order for a PT/INR every week starting 10/17/11. A physician's order, dated 10/20/11, indicated to hold the Coumadin for two			

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	days and to repeat the PT/INR on Saturday 10/22/11. There was a lack of documentation to indicate the PT/INR had been completed on 10/22/11. During an interview on 10/24/11 at 12:45 p.m., the DoN indicated the PT/INR had not been completed on 10/22/11 as ordered. During an interview on 10/24/11 at 1:10 p.m., RN #1 indicated the nurse had not called the lab company to tell them the PT/INR had been ordered for 10/22/11. This federal tag relates to complaint IN00098705. 3.1-35(g)(1)			

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F0329 SS=J	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to monitor residents' PT (pro-time) and INR (international normalized ratio) (laboratory blood clotting test) levels as ordered, which resulted in a resident receiving Vitamin K (given for blood coagulation) due to a critically high PT/INR (Resident #B) and the facility also failed to notify resident's physicians timely of high PT/INR's, which resulted in changes in the resident's Coumadin orders. This affected 3 of 4 residents who received Coumadin in a	F0329	1) Resident #B no longer resides at facility, however, the physician was notified of the PT/INR results and addressed the issue with no further negative outcomes. Residents #D, #E and #F had pertinent labs drawn at the time of survey. The residents were evaluated and no negative outcomes were noted.2) Current residents receiving Coumadin have the potential of being affected by this alleged deficiency. Current residents receiving Coumadin and requiring PT/INR's were identified. Lab	11/16/2011

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	sample of 4. (Residents #B, #D, and #E) In addition to the residents in immediate jeopardy, the facility failed to monitor a PT and INR for 1 of 2 residents receiving Coumadin in a supplemental sample of 2. (Resident #F) The immediate jeopardy began on 10/10/11 when the facility failed to notify a resident's physician in a timely manner of a high PT/INR, which the physician held the Coumadin for two days, failed to notify two other resident's physicians timely of high PT/INR's and failed to protect the resident from undue adverse medication consequences by not obtaining a PT/INR as ordered by the physician. The Executive Director, Director of Nursing, Corporate RN Consultant, and the Divisional Vice President were notified of the immediate jeopardy at 5:45 p.m. on 10/24/11. The immediate jeopardy was removed on 10/25/11 at 3:50 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Resident #B's record was reviewed on 10/24/11 at 2:15 p.m. The resident's diagnoses included, but were not limited		results were reviewed and physicians were notified of results accordingly.3) The deficiency was evaluated relative to system, education and compliance. The facility practice for reporting lab results to the physician was reviewed and nursing staff was in-serviced by the DHS or designee on the policy addressing reporting lab results. The lab tracking log and individual Coumadin records were implemented with nursing staff in-serviced on completion of the forms. 4) The DHS or designee will audit current residents requiring the use of Coumadin 7 days per week for 2 months, then 4 times per week for 2 months, then 3 times per week for 2 months.[See Attachment B, Resident Coumadin/Coag Testing Record]. Results from the audits will be reviewed by the DHS or designee and forwarded to the Quality Assurance Committe for 6 months or until 100% compliance is achieved.	

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	to, deep vein thrombosis (blood clot) and hypertension. The resident was admitted into the facility on 10/08/11 from the hospital. An admission order, dated 10/08/11 indicated an order for Coumadin 2.5 mg daily and to check the resident's INR weekly. A PT/INR result, dated 10/10/11, indicated the resident's PT was high at 36.6 (normal 10-12) and the INR was high at 4 (normal 2-3). The results indicated they had been faxed to the facility on 10/10/11 at 8:52 a.m. Written on the bottom of the PT/INR results indicated the physician was notified of the results at 2:40 p.m., no date was documented. The writing indicated, "Hold Coumadin x(times) 2 days, then resume @ (at) 2 mg, PT/INR on Mon. 10/17/11." A nurses' note, dated 10/12/11 at 2:40 p.m., indicated, "Spoke c/ (with) (physician's name), informed him abnormal labs. Rec'v (received) new orders..." A physician's telephone order, dated 10/12/11 at 2:40 p.m., which was two days after the facility had been notified of the PT/INR results, indicated, "(1) Hold Coumadin x2 day (sic) (2) then resume Coumadin @ 2 mg daily (3) Draw			

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	PT/INR on Mon 10/17/11". The resident's MAR (Medication Administration Record), dated 10/11, indicated the resident received 2.5 mg of Coumadin on 10/10/11 and 10/11/11 at supper and the Coumadin was held on 10/12/11 and 10/13/11. The MAR, dated 10/11, indicated the resident received Coumadin 2 mg daily at supper on 10/14/11, 10/15/11, 10/16/11, and 10/17/11. The MAR, dated 10/11, indicated the resident was scheduled to get a PT/INR on 10/17/11. There were no initials on the MAR to indicate the PT/INR on 10/17/11 had been completed. The resident's record lacked documentation to indicate a PT/INR had been completed on 10/17/11. A PT/INR result, dated 10/18/11, indicated a high PT of 85.5 (normal 10-12) and a critical INR of 10.4 (normal 2-3). A physician's telephone order, dated 10/18/11 at 8:30 a.m., indicated, "(1) Give vitamin K 10 mg IM (intramuscularly) now (2) Repeat PT/INR 10/19/11 (3) Hold Coumadin today"			

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	The PT/INR results, dated 10/19/11, indicated a PT at 31.7 and INR at 3.4. During an interview on 10/24/11 at 3:05 p.m., the Corporate RN Consultant indicated the lab company had not drawn the PT/INR on 10/17/11. During an interview on 10/24/11 at 4:15 p.m., the DHS (Director of Health Services) indicated a lab requisition had not been filled out for the PT/INR on 10/17/11. During an interview on 10/24/11 at 4:35 p.m., the DHS indicated the facility had not been aware the PT/INR had not been completed on 10/17/11 until 10/24/11 at 3:05 p.m. A facility policy, dated 11/22/08 and received from the DHS as current, titled, "Lab Tracking Guidelines", indicated, "To facilitate a method of tracking laboratory tests ordered and monitor test has been completed in a timely manner...2. The nursing staff or person designated by the Executive Director or Director of Health Services shall monitor the "Tracking Log" to ensure tests have been completed per the physician's order. 3. When results are received it shall be so noted on the "Tracking Log" with the physician			

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	notified of the results..." 2. Resident #D's record was reviewed on 10/24/11 at 11:50 a.m. The resident's diagnoses included, but were not limited to, multiple pulmonary emboli (blood clots) and coronary artery disease. A PT/INR lab result, dated 10/04/11, and faxed to the facility on 10/04/11 at 7:17 a.m., indicated the resident's physician was notified of the high PT result of 28.7 and INR of 3.1, on 10/05/11 at 2 p.m., which was over 24 hours after the results had been faxed to the facility. A physician's order, dated 09/27/11 at 8 p.m., indicated the resident had received Coumadin 5 mg alternating every day with Coumadin 2.5 mg. A physician's telephone order, dated 10/05/11 at 2 p.m., indicated to discontinue the previous order for Coumadin and to start Coumadin 2.5 mg for two days then Coumadin 5 mg for one day and alternate the doses, and to repeat the PT/INR in 10 days on 10/15/11. There was a lack of documentation to indicate the PT/INR had been completed on 10/15/11 as ordered by the physician. A PT/INR result, dated 10/18/11,			

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	indicated a PT of 20.4 and an INR of 2.1. The writing on the bottom of the result form indicated to continue the same dose (Coumadin) and to repeat the PT/INR in two weeks. During an interview on 10/24/11 at 12:15 p.m., RN #1 indicated the PT/INR had not been completed because 10/15/11 was a week-end (Saturday). She indicated there was no physician's order to change the date of the PT/INR. During an interview on 10/24/11 at 1:10 p.m., RN #1 indicated the lab company will do labs on the week-end but they are considered STAT (immediately) and the nurse has to call them. She indicated the nurse had not called the lab to tell them the PT/INR was ordered for 10/15/11. 3. Resident #E's record was reviewed on 10/24/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and coronary artery disease. A physician's telephone order, dated 10/12/11 indicated an order for a PT/INR every week starting 10/17/11. A PT/INR result, dated 10/17/11, indicated the results were faxed to the facility on 10/17/11 at 8:15 a.m. The			

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	PT/INR results indicated the facility had attempted to notify the resident's physician on 10/17/11 at 1:15 p.m., 2:30 p.m., 7:15 p.m., and 10:15 p.m. of the residents high PT at 33 and INR at 3.6. The form indicated the physician had not responded to the pages. The PT/INR results indicated the physician had been made aware of the PT/INR results on 10/18/11 at 8 a.m. (24 hours later). The physician had wrote on the PT/INR results to see order. A signed physician's order, dated 10/19/11 at 2:20 p.m., indicated to hold the Coumadin 10/19/11 and then to start Coumadin 1 mg daily. The resident's MAR, dated 10/11, indicated the resident had an order for Coumadin 2 mg, take 1/2 tablet daily (1 mg) at 5 p.m. and the resident had received the Coumadin 1 mg on 10/17/11 and 10/18/11. A physician's order, dated 10/20/11, indicated to hold the Coumadin for two days and to repeat the PT/INR on Saturday 10/22/11. There was a lack of documentation to indicate the PT/INR had been completed on 10/22/11.			

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During an interview on 10/24/11 at 12:45 p.m., the DoN indicated the PT/INR had not been completed on 10/22/11 as ordered.

During an interview on 10/24/11 at 1:10 p.m., RN #1 indicated the nurse had not called the lab company to tell them the PT/INR had been ordered for 10/22/11.

The facility policy titled "Physician Notification Guidelines" was received as current from the Executive Director on 10/24/11 at 6:00 p.m.,indicated "...To ensure the resident's physician is aware of all diagnostic testing results or change of condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...12. If the attending physician does not respond to notification attempts after three phone calls the Medical Director and Director of Health Services should be notified for further instructions."

4. The record for Resident #F was reviewed on 10/25/11 at 9:10 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, coronary artery disease, and peripheral vascular disease. The resident was admitted to the facility on 10/7/11.

A Physician's Order dated 10/7/11,

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	indicated the resident was to receive Coumadin (a blood thinner) 5 milligrams (mg) by mouth daily. The resident did not have any laboratory orders for a PT/INR at the time of admission. The plan of care dated 10/18/11, indicated the resident was at risk for bleeding related to anti-coagulant use and aspirin use. The interventions indicated to provide the anti-coagulant medication as prescribed by the physician, and report lab results to physician and follow physician recommendations for abnormal labs. A Physician's Order dated 10/24/11, indicated the resident was to have a STAT PT/INR. The results were dated 10/24/11 and faxed to the facility at 7:45 p.m. The resident's Protime (PT) was high at 58.6. Normal 10-12 seconds. The resident's INR value was critical at 6.8. The physician was notified at 7:50 p.m., and orders were received to hold the Coumadin for two days and repeat the PT/INR on 10/27/11. On 10/27/11, the resident's Coumadin was to be decreased from 5 mg to 3 mg daily. The "Resident Coag Testing Record" located in the Medication Administration Record (MAR), indicated the only PT/INR listed as being completed was on 10/24/11.			

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	Interview with LPN #1 on 10/25/11 at 10:18 a.m., indicated that when a resident was admitted on Coumadin, she would notify the physician and ask for PT/INR orders. She further indicated the residents on Coumadin usually have a PT/INR drawn weekly. Interview with the DHS on 10/25/11 at 10:55 a.m., indicated the resident did not have a physician's order for a PT/INR at admission. She indicated the PT/INR drawn on 10/24/11 was the first one that had been drawn since admission. She further indicated the frequency of the lab draw was determined by the physician and that PT/INR's were usually drawn once a week or once every two weeks for residents receiving Coumadin. The immediate jeopardy that began on 10/10/11 was removed on 10/25/11 when the facility had audited the residents' records who received Coumadin for PT/INR's and other laboratory testing. and deficiencies were corrected. The facility obtained orders for PT/INR's for residents who did not have physician's order to monitor. Quality Assurance audits were initiated to monitor PT/INR and other labs to ensure they are completed as ordered, timely physician notification, and changes in resident orders. 28 of 35 nurses had			

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	been inserviced and the nurses who had not been inserviced are scheduled to be inserviced prior to reporting for duty. Four nurses were interviewed and they were able to state the facility protocol for lab results, physician notification, and ordering new lab tests. The DHS or her designee will audit all physician orders and labs daily, seven days a week, including Coumadin tracking logs for deficiencies and nurses will be re-inserviced on the Coumadin monitoring process and correct any deficiencies if they are found. Audits will be completed seven days a week for two months, then four times a week for two months, then three times a week for two months. The DHS will report findings to the Quality Assurance Committee monthly for six months. This federal tag relates to complaint IN00098705. 3.1-48(a)(3)			

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F0385 SS=D	A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Based on record review and interview, the facility failed to ensure a physician provided medical care to a resident when the resident's physician had not responded to the facility staff to treat a high PT (pro-time) and INR (international normalized ratio) (laboratory blood clotting test) levels for 1 of 4 resident's reviewed for physician responding for medical care in a total sample of 4. (Resident #E) Findings include: Resident #E's record was reviewed on 10/24/11 at 12:30 p.m. The resident's diagnoses included, but were not limited	F0385	1. Resident #E's chart was reviewed and physician was notified during time of the survey. No negative outcomes noted.2. Current residents have the potential to be effected by the alleged deficiency. Current residents were reviewed for supervision of physician services.3. The deficiency was evaluated relative to system, education and compliance. Licensed staff will be in-serviced by DHS or designee on Physician Notification Guidelines.4. The DHS or designee will audit all residents requiring necessary lab services 7 days per week for 2 months, then 4 days per week for 2 months, then 3 days per week for 2 months. [See Attachments A and B]. Results from the audits will be reviewed by the DHS or	11/16/2011

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	to, congestive heart failure and coronary artery disease. A physician's telephone order, dated 10/12/11 indicated an order for a PT/INR every week starting 10/17/11. A PT/INR result, dated 10/17/11, indicated the results were faxed to the facility on 10/17/11 at 8:15 a.m. and the resident's PT was high at 33 (normal 10-12) and the INR was 3.6 (normal 2-3). The PT/INR results indicated the facility had attempted to notify the resident's physician on 10/17/11 at 1:15 p.m., 2:30 p.m., 7:15 p.m., and 10:15 p.m. of the residents high PT at 33 and INR at 3.6. The form indicated the physician had not responded to the pages. The PT/INR results indicated the physician had been made aware of the PT/INR results on 10/18/11 at 8 a.m. (24 hours later). The physician had wrote on the PT/INR results to see order. A signed physician's order, dated 10/19/11 at 2:20 p.m., indicated to hold the Coumadin 10/19/11 and then to start Coumadin 1 mg daily. During an interview on 10/24/11 at 12:45 p.m., RN #1 indicated the staff should have called the Medical Director if the		designee and forwarded to the Quality Assurance Committe for 6 months or until 100% compliance is achieved.	

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	physician had not answered his pages. The facility policy titled "Physician Notification Guidelines" was received as current from the Executive Director on 10/24/11 at 6:00 p.m.,indicated "...12. If the attending physician does not respond to notification attempts after three phone calls the Medical Director and Director of Health Services should be notified for further instructions." This federal tag relates to complaint IN00098705. 3.1-22(a) 3.1-22(a)(1) 3.1-22(a)(2)			
F0505 SS=E	The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to promptly notify residents'	F0505	1. The physician was notified of the lab results for Residents #B, #E, #D and #G. No negative	11/16/2011

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	physicians of PT (pro-time) and INR (international normalized ratio) (laboratory blood clotting test) levels for 3 of 4 residents reviewed for timely physician notification of laboratory (lab) tests in a sample of 4 (Residents #B, #D, and #E) and 1 of 2 residents in a supplemental sample of 2 (Resident #G). Findings include: 1. Resident #B's record was reviewed on 10/24/11 at 2:15 p.m. The resident's diagnoses included, but were not limited to, deep vein thrombosis and hypertension. The resident was admitted into the facility on 10/08/11 from the hospital. An admission order, dated 10/08/11 indicated an order for Coumadin 2.5 mg daily and to check the resident's INR weekly. A PT/INR result, dated 10/10/11, indicated the resident's PT was high at 36.6 (normal 10-12) and the INR was high at 4 (normal 2-3). The results indicated they had been faxed to the facility on 10/10/11 at 8:52 a.m. Written on the bottom of the PT/INR results indicated the physician was notified of the results at 2:40 p.m., no date was documented. The writing indicated, "Hold Coumadin x(times) 2 days, then resume @ (at) 2 mg,		outcomes noted.2. Current residents receiving lab services have the potential to be effected by the alleged deficiency. Current residents were reviewed for physician notification of lab results and/or change of condition. Physicians were notified of results accordingly.3. The deficiency was evaluated relative to system, education and compliance. Licensed staff will be in-serviced by DHS or designee on Physician Notification Guidelines.4. The DHS or designee will audit current residents requiring lab services 7 days per week for 2 months, then 4 days per week for 2 months, then 3 days per week for 2 months. [See Attachment A]. Results from the audits will be reviewed by the DHS or designee and forwarded to the Quality Assurance Committee for 6 months or until 100% compliance is achieved.	

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	PT/INR on Mon. 10/17/11." A nurses' note, dated 10/12/11 at 2:40 p.m., indicated, "Spoke c/ (with) (physician's name), informed him abnormal labs. Rec'v (received) new orders..." A physician's telephone order, dated 10/12/11 at 2:40 p.m., which was two days after the facility had been notified of the PT/INR results, indicated, "(1) Hold Coumadin x2 day (sic) (2) then resume Coumadin @ 2 mg daily (3) Draw PT/INR on Mon 10/17/11". During an interview on 10/24/11 at 5:15 p.m., the Director of Health Services acknowledged the lab had been faxed to the facility on 10/10/11 at 8:52 a.m. No further information was given. 2. Resident #D's record was reviewed on 10/24/11 at 11:50 a.m. The resident's diagnoses included, but were not limited to, multiple pulmonary emboli and coronary artery disease. A PT/INR lab result, dated 10/04/11, and faxed to the facility on 10/04/11 at 7:17 a.m., indicated the resident's physician was notified of the high PT result of 28.7 and INR of 3.1, on 10/05/11 at 2 p.m., which was over 24 hours after the results			

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	had been faxed to the facility. 3. Resident #E's record was reviewed on 10/24/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and coronary artery disease. A physician's telephone order, dated 10/12/11 indicated an order for a PT/INR every week starting 10/17/11. A PT/INR result, dated 10/17/11, indicated the results were faxed to the facility on 10/17/11 at 8:15 a.m. The PT/INR results indicated the facility had attempted to notify the resident's physician on 10/17/11 at 1:15 p.m., 2:30 p.m., 7:15 p.m., and 10:15 p.m. of the residents high PT at 33 and INR at 3.6. The form indicated the physician had not responded to the pages. The PT/INR results indicated the physician had been made aware of the PT/INR results on 10/18/11 at 8 a.m. (24 hours later). The physician had wrote on the PT/INR results to see order. A signed physician's order, dated 10/19/11 at 2:20 p.m., indicated to hold the Coumadin 10/19/11 and then to start Coumadin 1 mg daily.			

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	During an interview on 10/25/11 at 8:35 a.m., the Corporate Divisional Vice President indicated there was a delay in physician notification of the lab results. 4. The record for Resident #G was reviewed on 10/25/11 at 8:45 a.m. The resident was first admitted to the facility in 7/29/11. The resident was readmitted to the facility on 9/1/11. The resident's diagnoses included, but were not limited to, malignant neoplasm of the bronchus and lung, congestive heart failure, high blood pressure, and malignant neoplasm of the brain. Review of the 9/1/2011 Physician orders indicated the resident was to receive Coumadin (an medication to thin the blood and prevent blood clots) 2.5 milligrams one tablet. There was also an order for PT/INR (blood tests to check clotting time) laboratory tests to be completed weekly starting on 9/5/11. A physician's order was written on 9/19/11, indicated to discontinue the Coumadin 2.5 milligrams and to start Coumadin 3.5 milligrams daily. A physician's order was written on 9/29/11 to increase the Coumadin to 5 milligrams one tablet daily starting on 9/30/11. Review of the 10/2011 laboratory tests results report indicated a PT/INR			

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	laboratory test was completed on 10/11/11. The PT/INR were as follows: PT 20.4 (normal 10-12) INR 2.1 (therapeutic range 2-3) Documentation on the results page indicated the results were faxed to the facility on 10/24/11. Documentation written on the results page also indicated the physician was notified on 10/24/11. A PT/INR laboratory test was completed on 10/18/11. The results were as follows: PT 19.6 INR 2.0 Documentation written on the results page indicated the results were faxed to the facility on 10/18/11 at 8:24 a.m. Documentation written on the results page also indicated the physician was notified on 10/24/11. Review of the 10/2011 Nurses' Progress Notes indicated there was no documentation of the physician being notified of the 10/11/2011 and 10/18/11 laboratory results prior to 10/24/2011. The daily "Skilled Nursing Assessment & Data Collection" forms completed 10/10/11 through 10/20/11 indicated there was no documentation of the physician being notified of the 10/11/11 and the 10/25/11 PT/INR. When interviewed on 10/25/11 at 9:10			

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	a.m., the Director of Nursing indicated the Medical Director was notified of the 10/18/11 results on 10/24/11. The Director of Nursing indicated the Medical Director was notified of the laboratory results on 10/24/11 after the facility had the results faxed over to the facility on 10/24/11. The facility policy titled "Physician Notification Guidelines" was received as current from the Executive Director on 10/24/11 at 6:00 p.m., indicated "...To ensure the resident's physician is aware of all diagnostic testing results or change of condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...12. If the attending physician does not respond to notification attempts after three phone calls the Medical Director and Director of Health Services should be notified for further instructions." The policy indicated the physician should be notified of critical lab results or an immediate need by phone as soon as the results are known. All other tests results or order requests may be faxed to the physician's office during office hours. Diagnostic tests results require a response from the physician noting they have reviewed the test results. This federal tag relates to complaint IN00098705.			

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	3.1-49(f)(2)			